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Patient Name: \_\_\_\_\_

**POINT PLACE DENTAL**

Notice of Privacy Practices

I acknowledge that I have received the Point Place Dental Notice of Privacy Practices that describes how my health information may be used or disclosed as required by federal law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**HIPAA Permission to Discuss Dental Information**

The privacy of your health information is very important to us. If you wish us to discuss information about your dental health with your family, friends, caregivers, or others, please indicate this by completing the information below.

I, \_\_\_\_\_, permit the discussion of my healthcare information for the purpose of communicating results, findings, care decisions, scheduling and billing/payment information to the following individuals:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

I understand that dental practice personnel will use their professional judgement to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Relationship to Minor

\_\_\_\_\_  
Date

*For Office Use Only*

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communication barriers prohibited obtaining acknowledgement
- \_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_\_\_ Other: \_\_\_\_\_